Jewish Tradition and Patient Communication

Jeffrey H. Lipton PhD MD FRCPC

Department of Medical Oncology and Hematology, Princess Margaret Cancer Centre, University of Toronto, Toronto, ON, Canada

ABSTRACT We can learn methods of how to communicate with patients from the Passover Haggadah. Patients are all not the same, and we must learn to communicate in different ways.

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From the first day of medical school, most physicians are indoctrinated with the concept that open communication with our patients is how medicine should be practiced. Regardless of our specialty, this forthright approach is thought to be the ideal. Whether it is taking a solid history, revealing a diagnosis, discussing therapeutic options and adverse events, discussing disease prognosis, or even conveying distressing information, this approach is the gold standard of management. We are communicating not only with the patient, but also with significant others such as family members, partners, and friends; therefore, the physician must often repeat the message to different listeners. In the environment of medicine today in Canada and in many other places, is this situation ideal, and if so what is the cost?

In the setting of shortages, whether it is manpower, access to consultation or testing, therapeutic maneuvers, or blunt cost, what are the issues to consider when properly communicating with the patient? In this focus article, I do not offer new insights, just a perspective.

Most workers in the medical field have little control over budgets. Salary or reimbursement is dictated by jurisdictional plans, and reward intervention may not consider time involved. Some discussions with patients take time and quite frankly, is that time rewarded?

There is a nationwide shortage of physicians in many countries. There is pressure for physicians to see more patients and to conduct more procedures. This combination often leads to less than gold standard-type visits. The number of patients needing to be seen is growing, and the quality of life for physicians has replaced the work-till-you-drop approach.

Another aspect involves second opinions, which are often requested, even for minor diagnoses. Patients may need these reassurances to help make informed decisions; however, these referrals may be made with multiple consultants so that the patient has the option to go to the first available appointment. Some patients request appointments from many practitioners, unaware that they are taking slots from more urgent situations. The availability of centralized records of patient visits and prescriptions would help with this problem. Generally, however, physicians have little control over these issues on an individual basis.

In a more ideal environment, patient communication would be more individualized. A recent phenomenon has been the idea of patient advocacy. Disease-specific patient groups are coalescing to help others to keep updated on new treatments as well as support for those with difficult diagnoses.

The concept of self-advocacy is important, and it is not new. In the tractate Pirkei Avot, Hillel the Elder stated more than 2000 years ago:

אִם אֵין אֲנִי לִי, מִי לִי?
וּכְשֶׁאֲנִי לְעַצְמִי, מָה אֲנִי?
וְאִם לֹא עַכְשָׁו, אֵימָתַי?

"If I am not for myself,
who is for me?
And if I am only for myself,
what am I?
And if not now, when?"

Advocacy groups offer support to bewildered and often frightened patients. These groups may make it easier for patients to understand and comprehend a diagnosis. Many of the advocacy groups have developed guidelines on how physicians should present relevant information to patients.

These advocacy groups usually consist of very committed and motivated individuals who are patients themselves or family or friends of patients. These individuals may come to the appointments having scrutinized the literature and may believe, in good faith, that they have a good understanding of the disease and the therapeutic options. In some cases, they actually tell the physician how the patient should be managed. Sometimes

they are right, but in many cases, they do not have the background to distinguish reliable information from marketing information. They also may have personal agendas or know how other patients were treated. Communication needs to involve setting the record straight, dealing with misconceptions, and making patients aware of the realities of available treatments. Physicians on chat lines are sometimes guilty of recommending options that are not available in all jurisdictions. Recommending treatment options and therapies recommended in the lay literature may make a physician uncomfortable.

So, how should physicians speak with their patients? Aside from a physician's discomfort with an unfamiliar diagnosis or therapy, not all patients are the same. They may differ on familiarity with language, education, comprehension, or cultural ideas. They may not want to, or be able to, comprehend all the information. Advocacy group guidelines are often compiled by informed, educated, and motivated individuals who know what they want and believe that everyone wants the same.

JEWISH HERITAGE

Pesach, or Passover, commemorates the Exodus led by Moses from Egyptian slavery some 3500 years ago. This week-long holiday begins with a festive meal, a Seder. The word *Seder* means order. The Seder often revolves around the telling of the Israelite's Exodus from Egypt using a book called the Haggadah. The oldest copies of the Haggadah date back to the 10th or 11th centuries. In the first part, the Haggadah tells the story of the four children: wise (*hacham*), contradictory one (*rasha*), uneducated (*tam*), and one who is too naïve to know what to ask (*meshelo yodea le'eshol*). Modern discussions often talk about a fifth child, the one who is conspicuously absent from the Seder. One of the duties of the Seder leader is to respond to the questions these children ask. Obviously, the leader cannot answer the four children in the same way.

These differences are ancient, yet still relevant, examples of why advocacy group guidelines, although nice, may not be appropriate for all patients. All our patients are different and need varying amounts of information presented in different ways. We see patients who want to know all the minutia of the basic science and clinical approach to a diagnosis and others who will argue with everything. Others may be non-compliant with treatments while others need to hear only the important basics. Yet others have no idea what to ask and generally just wants to be told what to do. A fifth type of patient may not care at all. In some cases, what the patient wants and what their companions want may be quite different. Pre-defined guidelines do not allow for these variations. These individuals need some form of communication, but non-patronizing information. However, not all information incorporates these differences.

CONCLUSIONS

Physicians need to communicate with their patients in a non-patronizing approach and explain the options, risks, and benefits in a way that the patient can understand. This approach can take time. Honesty from the physician is important. Referring the patient to a professional with more expertise may be appropriate. In this situation, because each patient is different, presenting the appropriate information in a fitting way is imperative. We can learn from the Passover Haggadah. Even if we know what to say, we need to know the audience before we can decide what is best.

Correspondence

Dr. J.H. Lipton
Dept. of Medical Oncology and Hematology
Princess Margaret Cancer Centre, Toronto, ON M5G 2M9, Canada
Phone: (1-416) 946-2267
Email: jeff.lipton@uhn.ca

Capsule

Meningococcal B vaccine to prevent Neisseria gonorrhoeae infection

This randomized clinical trial, by **Seib** et al. evaluated whether a licensed MenB vaccine could reduce the incidence of laboratory-confirmed gonorrhea. Vaccination significantly lowered the risk of gonorrhea compared with the control group, providing moderate but clinically meaningful protection. The vaccine demonstrated a favorable safety profile, with mostly mild local and systemic adverse reactions. The findings support the concept that existing MenB vaccines may offer dual protection against meningococcal disease and gonorrhea, representing a promising public health strategy while gonorrhea-specific vaccines continue to be developed.

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Eitan Israeli